OFFICIAL USE ONLY:

FACILITY # _____ DATE RECEIVED: _____

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD CARE & EARLY CHILDHOOD EDUCATION

APPLICATION FOR CHILD CARE LICENSE/REGISTRATION

(THIS APPLICATION WILL NOT BE CONSIDERED COMPLETE UNTIL ALL INFORMATION HAS BEEN PROVIDED.)

PLEASE MARK THE TYPE(S) OF LICENSE/REGISTRATION FOR WHICH YOU ARE APPLYING:

___ 1. CHILD CARE CENTER
- ___ A. INFANT & TODDLER (0-36 MONTHS)
- ___ B. PRESCHOOL (2 ½ - 5 YEARS)
- ___ C. SCHOOL AGE (KINDERGARTEN & UP)
- ___ D. SICK CARE

___ 2. LICENSED CHILD CARE FAMILY HOME

___ 3. REGISTERED CHILD CARE FAMILY HOME

___ 4. RELATIVE CHILD CARE FAMILY HOME

FACILITY NAME: _____

SITE ADDRESS: _____
STREET CITY STATE ZIP

MAILING ADDRESS: _____
STREET CITY STATE ZIP

COUNTY: _____ FACILITY PHONE: (_____)_____

*OWNER (WHO OWNS THE FACILITY) NAME: _____

*IF A BOARD WILL BE THE OWNER, ATTACH A COPY OF BOARD MEMBER NAMES, ADDRESSES AND PHONE NUMBERS. IN ADDITION, A COPY OF ARTICLES OF INCORPORATION, WHICH HAVE BEEN FILED WITH THE SECRETARY OF STATE AND ANY AMENDMENTS, SHALL ALSO BE PROVIDED.

OWNER MAILING ADDRESS: _____
STREET CITY STATE ZIP

OWNER PHONE: (_____)_____

TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER: _____

DATE TO BEGIN OPERATION: _____ OWNER FISCAL/TAX YEAR: _____ (MONTH) TO _____ (MONTH)

HOURS OF OPERATION:

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
OPEN							
CLOSE							

MONTHS OF OPERATION (PLEASE MARK THE MONTHS YOUR FACILITY WILL BE OPEN.):

ALL	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC

DIRECTIONS TO FACILITY:

_____

_____

_____

RATES TO BE CHARGED:

	PART-TIME	HALF-TIME	FULL TIME	NIGHT CARE	WEEK-END	SPECIAL NEEDS
INFANTS (0-18)						
TODDLER (18-36)						
PRESCHOOL (30-71)						
SCHOOL AGE (60-155)						

PART-TIME: LESS THAN THREE HOURS BUT NOT INCLUDING THREE HOURS
HALF-TIME: THREE HOURS UP TO FIVE HOURS BUT NOT INCLUDING FIVE HOURS
FULL TIME: FIVE TO TEN HOURS
NIGHT TIME: FIVE TO TEN HOURS, WHERE HALF OF THE TIME IS LATER THAN 6:00 PM
WEEK-END: FIVE TO TEN HOURS ON SATURDAYS & SUNDAYS
NOTE: HOURS DO NOT HAVE TO BE CONSECUTIVE

HAS ANYONE IN YOUR IMMEDIATE FAMILY (BLOOD RELATIVE; BY MARRIAGE; ETC.) OR ANYONE AFFILIATED WITH YOUR FACILITY (SHARING COMMON OWNERSHIP; BOARD MEMBER; OR ANY OTHER INTEREST) EVER BEEN DEBARRED, TERMINATED, SUSPENDED OR OTHERWISE EXCLUDED FROM PARTICIPATION BY A GOVERNMENT UNIT?

YES _____ NO _____

IF YOU ANSWERED YES, PLEASE LIST THE NAME OF THE PARTY OR ENTITY EXCLUDED: _____

RELATIONSHIP TO YOU: _____

NAME OF CENTER OR HOME EXCLUDED: _____

PLEASE ATTACH THE FOLLOWING ITEMS:

1. DIAGRAM OF THE FACILITY/BUILDING, WHICH INDICATES ROOMS USED BY CHILDREN AND LOCATIONS FOR HAND WASHING AND TOILETING.
2. CRIMINAL RECORD, CHILD MALTREATMENT CENTRAL REGISTRY AND FBI RECORD CHECKS ON APPLICANT.
3. COPIES OF FIRE AND HEALTH DEPARTMENT APPROVALS (IF APPLICABLE).
4. CENTERS ONLY – NAME OF PROPOSED DIRECTOR AND DOCUMENATION OF QUALIFICATIONS.
5. LICENSED/REGISTERED/RELATIVE CHILD CARE FAMILY HOMES ONLY: NAME OF ALL CAREGIVERS WITH THEIR AGES, ADDRESSES AND PHONE NUMBERS **AND** ALL OTHER RESIDENTS OF THE HOME.
6. ZONING APPROVAL (IF APPLICABLE)
7. MOBILE HOME COMMISSION STATEMENT (IF APPLICABLE)

"UNDER THE PROVISIONS OF THE CHILD CARE LICENSING ACT 434 OF 1969, AMENDED, I HEREBY MAKE APPLICATION FOR LICENSE/REGISTRATION TO OPERATE A CHILD CARE CENTER/HOME. I HAVE REVIEWED THE MINIMUM LICENSING/REGISTRATION REQUIREMENTS AND AGREE TO COMPLY WITH THEM."

_____ _____

SIGNATURE OF OWNER** DATE

**A LETTER OF AUTHORIZATION IS ALSO REQUIRED IF THE PERSON SIGNING IS ANYONE OTHER THAN THE OWNER.

MAIL TO: YOUR CHILD CARE LICENSING SPECIALIST